TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Amtrust Insurance Co

MFDR Tracking Number
M4-23-1260-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
February 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 4, 2022	97750-FC	$502.08	$372.80
August 23, 2022	97545-WH	$102.40	$51.20
August 23 2022	97546-WH	$51.20	$51.20
September 14, 2022	97545-WH	$51.20	$0.00
September 28, 2022	97545-WH	$51.20	$0.00
October 31, 2022	97545-WH	$102.40	$51.20
October 31, 2022	97546-WH	$51.20	$51.20
	Total	$911.68	$577.60

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "I have attached the authorization for these dates of service. These services billed are preauthorized work hardening visits."

Amount in Dispute: $911.68

Respondent's Position

The Austin carrier representative for Amtrust Insurance Co is Downs Stanford. The representative

was notified of this medical fee dispute on February 7, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out guidelines for medical fee dispute resolution.

2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for Work Hardening.

3. 28 Texas Administrative Code §124.2 sets out Plain Language Notification requirements.

4. 28 Texas Administrative Code 134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P4 – Workers' compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.

- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did the insurance carrier meet the requirements of Plain Language Notification?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the rule applicable to reimbursement of Functional Capacity Evaluations?
4. What rule is applicable to work hardening?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier indicates in an explanation of benefits the services are non-compensable.

   DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.
2. The requestor is seeking reimbursement for professional medical services in August through October 2022. The insurance carrier reduced their payment based on workers' compensation fee schedule. The services in dispute will be reviewed per applicable fee guidelines.
3. The Functional Capacity Evaluation (FCE) is reimbursed per DWC Rule §134.204 (g) which states FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title.

   DWC Rule 28 TAC §134.203 (c) (1) states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when

performed in an office setting, the established conversion factor to be applied is yearly conversion factor of disputed services.

The applicable Medicare payment policy for physical therapy is Multiple Procedure Payment Reduction (MPPR).

The Medicare multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day.
The *MPPR Rate File* that contains the payments for 2022 services is found at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- The services were provided in Garland, Texas.
- The carrier code for Texas is 4412 and the locality code for Garland Texas is 11.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

- DWC Conversion Factor $62.46
- Medicare Conversion Factor $34.6062
- MPPR Rate $34.77 first unit
- MPPR Rate $24.54 second through eighth units
- 62.46/34.6062 x 34.77 = $62.76
- 62.46/34.6062 x 24.54 x 7 = $310.04
- Total MAR $372.80

4. DWC Rule §134.204 (h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

   (1) Accreditation by the CARF is recommended, but not required.

   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. **The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR**.

DWC Rule §134.204 (h) (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

- Date of service August 23, 2022, 97545 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20
- Date of service August 23, 2022, 97546 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20
- Date of service September 14, 2022, 97545 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20
- Date of service September 28, 2022, 97545 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20
- Date of service October 31, 2022, 97545 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20
- Date of service October 31, 2022, 97546 WH (1) unit. Reimbursement rate of $64 at 80% = $51.20

5. The total maximum reimbursement allowable for all eligible disputed services is $680.00. The insurance carrier paid $102.40. The remaining balance of $577.60 is due to the requestor.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Amtrust Insurance Co must remit to Peak Integrated Healthcare $577.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 17, 2023
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.